

fresh lesions were seen, and his general condition and the lesions improved rapidly.

**Case 2**—A 12 year old European boy was admitted with fever, considerable herpetiform eruption on his face and neck, and severe angio-oedema of periorbital tissues (figure). The eruption had begun four to five days previously and had spread explosively. He had a history of atopic eczema from infancy, but there had been good spontaneous improvement over the past year or two. No pyogenic organisms were isolated from repeated blood cultures and multiple skin swabs. Virus culture confirmed a diagnosis of herpes simplex infection. The vesicles continued to spread and disseminate, and he was given oral acyclovir 200 mg every four hours five times daily for five days. This dosage was equivalent to 25 mg/kg body weight/day. No further eruption of herpetic lesions occurred (figure), and no evidence of herpetic infection was detected in his eyes. He was also treated with flucloxacillin and sodium fusidate ointment to prevent secondary bacterial infection.

### Comment

Both these patients showed a good clinical response to oral treatment with acyclovir, and the infection did not recur during three months of follow up. This treatment caused no discomfort to the patients and had no apparent side effects.<sup>2</sup> There is not yet an established dosage for children,<sup>3</sup> and possibly a higher dosage than was used in these children might have been more beneficial as their renal function was normal and only 20% of acyclovir is absorbed from the gut.<sup>4</sup>

<sup>1</sup> Fawcett HA, Wansbrough-Jones MH, Clark AE, Leigh IM. Prophylactic topical acyclovir for frequent recurrent herpes simplex infection with and without erythema multiforme. *Br Med J* 1983;287:798-9.

<sup>2</sup> Swart RNJ, Vermeer BJ, Der Meer JWM, Enschede FAJ, Versteeg J. Treatment of eczema herpeticum with acyclovir. *Arch Dermatol* 1983; 119:13-6.

<sup>3</sup> Gould JM, Chessells JM, Marshall WC, McKendrick GDW. Acyclovir in herpesvirus infections in children. *Journal of Infection* 1982;5:283-9.

<sup>4</sup> Wellcome Medical Division. *Zovirax*. Beckenham, Kent: Burroughs Wellcome, 1983. (Data sheet.)

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## Cuboidal calcium enterolith causing obstruction and perforation of small intestine

Intestinal strictures are a rare cause of calcium enteroliths, and perforation as a complication has only once been reported.<sup>1</sup> We report on a patient with a cuboidal enterolith; this has never previously been described.

### Case report

A 56 year old man was admitted to hospital as an emergency with a three day history of intermittent epigastric pain, which had been severe but had subsequently eased off. He reported having had similar episodes of pain about twice a year for the past few years. His only medical history was of an appendicectomy when he was 11 years old. He had not received any recent medical treatment. On admission his abdomen was slightly distended and tender in the hypogastrium, with increased bowel sounds. Plain radiographs showed distended loops of small bowel and a square opacity, with a lucent centre, adjacent to the left sacroiliac joint (figure). The pain and tenderness resolved within a few hours and he was allowed home.

A week later he was readmitted. On that day the pain had become suddenly more severe and was exacerbated by movement. On examination he was feverish (temperature 37.7°C) and his abdomen rigid. Plain radiographs showed no free gas but some fluid levels in the small bowel. At laparotomy he was found to have peritonitis. His stomach, duodenum, liver, and gall bladder were normal. A large mass was fixed in the left iliac fossa and contained loops of small bowel. The mass was resected and a primary anastomosis performed. Postoperatively he made a good recovery. Subsequent follow up showed him to have gained weight and to be free of pain. Plain abdominal radiography showed no other calcified lesions, and a barium meal and follow through did not detect any abnormalities.

In the resected ileum a 2 cm perforation was found 2.5 cm proximal to an impacted cuboidal hard stone 1.7 × 1.5 × 1.2 cm. Immediately distal to the stone was a fibrous stenosis of the bowel wall. The proximal segment showed

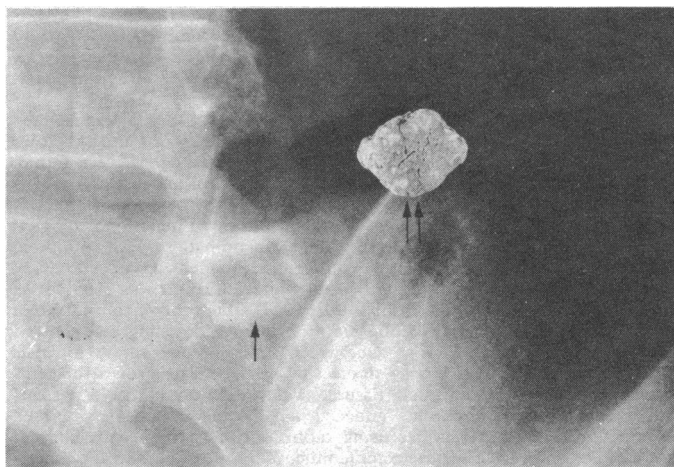
muscular hypertrophy and two ulcerated areas, one of which had perforated. There were no specific features present and in particular no evidence of Crohn's disease, tuberculosis or an ischaemic aetiology.

The stone had hard outer walls composed almost entirely of calcium oxalate. The soft brown core contained some histologically identifiable plant material. Electron probe analysis of the wall confirmed the high calcium content. The patient could not recall having ingested any cuboidal vegetable or fruit.

### Comment

Calcium enteroliths are rare and usually develop in the distal small bowel. They are associated with stasis, often related to an intestinal stricture caused by tuberculosis or Crohn's disease.<sup>2</sup> The more common type of enterolith has a high content of choleic acid and develops in acquired or congenital diverticula.<sup>3</sup>

Many enteroliths are thought to form around a nucleus, which is usually of plant material, especially fruit skins and stones. Experimental studies have shown that ingested material that swells may cause an obstruction and that oblong objects are slower in their progress through the bowel than round objects.<sup>4</sup> Fruit pith and skins may produce an ileus at a site of slight stenosis.<sup>5</sup>



Close up of plain abdominal radiograph recorded on admission showing square opacity with lucent centre (↑). Enterolith after removal is superimposed (↑ ↑).

Our patient's long history of intermittent colic suggests that the enterolith had been present at that site for some time and a source of mucosal irritation with subsequent fibrosis. We believe that the most likely course of events was impaction of ingested plant material at a slight ileal stricture without obstruction; formation of a crust of calcium oxalate around this nucleus; excitation of chronic inflammation and fibrosis leading to further narrowing of the segment of the bowel; and finally complete obstruction and perforation. The curious, precise cuboidal shape of the enterolith remains unexplained.

We thank Mr J B Bourke for allowing us to report on his patient and for his help.

<sup>1</sup> Zeit RM. Enterolithiasis associated with ileal perforation in Crohn's disease. *Am J Gastroenterol* 1979;72:662-4.

<sup>2</sup> Atwell JD, Pollock AV. Intestinal calculi. *Br J Surg* 1960;47:367-74.

<sup>3</sup> Shockett E, Simon SA. Small bowel obstruction due to an enterolith formed in a duodenal diverticulum. A case report and review of the literature. *Am J Gastroenterol* 1982;77:621-4.

<sup>4</sup> Harjola PT, Scheinin TM. Experimental observations on intestinal obstruction due to foreign bodies. *Acta Chir Scand* 1963;126:144-7.

<sup>5</sup> Ward-McQuaid N. Intestinal obstruction due to food. *Br Med J* 1950;i: 1106-9.

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